MINUTES OF MEETING OF
HEALTH STRATEGIES COUNCIL
Department of Community Health, Division of Health Planning
2 Peachtree Street, DHR Board Room, 29th Floor, Atlanta, GA 30303
Friday, November 19, 2004
11:00 am – 1:00 pm

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Daniel W. Rahn, M.D., Chair, Presiding

MEMBERS PRESENT

William G. "Buck" Baker Jr., M.D.
Honorable Glenda M. Battle, RN, BSN
Harve R. Bauguess
David Bedell, DVM
Edward J. Bonn, CHE
Tary Brown
W. Clay Campbell
Nelson B. Conger, DMD
Katie B. Foster
Charlene M. Hanson, Ed.D.,FNP
Reverend Ike E. Mack
Felix Maher, DMD
James G. Peak
Raymer Martin Sale, Jr.
Toby D. Sidman
Oscar S. Spivey, MD
Tracy M. Strickland
Kurt M. Stuenkel, FACHE
Katherine L. Wetherbee
David M. Williams, MD

MEMBERS ABSENT

Elizabeth Brock
Julia L. Mikell, MD
Catherine Slade

GUESTS PRESENT

Judy Adams, Ga. Assoc. of Home Health Agencies
Jennifer Bach, Mitretek Healthcare Gill/Balsano
Billy J. Baron, Georgia Healthcare Association
Charlotte W. Bedell, Tift County Commission
Cliff Campbell, Jr.
Webb Cochran, Tenet
Brian Crevasse, Parker Hudson, Rainer & Dobbs
Bill Everage, Forest Pharmacy
Nelda Greene, Georgia Dental Association
Jon Howell, Georgia Nursing Home Association
Lori Jenkins, Phoebe Putney Memorial Hospital
Bill Lewis, Phoebe Putney Health System
Erin Moriarty, Atlanta Business Chronicle
Mark Mullin, Gwinnett Health System
Kevin Rowley, St. Francis Hospital
Helen Sloat, Nelson Mullins

STAFF PRESENT

Charemon Grant, JD
Richard Greene, JD
Robert Rozier, JD
Rhathelia Stroud, JD
Stephanie Taylor

WELCOME AND CALL TO ORDER

The Health Strategies Council meeting was convened at 11:05 am. Dr. Rahn welcomed Council members and guests and called for a motion to accept the minutes of the August 27th meeting. Prior to approval, Ed Bonn asked for clarification of the word "committee" which appeared under the Department Report/Cardiovascular Services -"CPORT II Update" (page 7 of the draft minutes) which reads as follows:

> "He indicated that in the meantime, Stephanie Taylor and other Department staff have collected articles, and other research materials to support the work of the committee when it is eventually convened".

Both Dr. Rahn and Mr. Greene clarified that the word "committee" referred to a "Technical Advisory Committee" which has not been convened at this time. Dr. Rahn recommended that the acronym (TAC) be inserted in the minutes next to the word "committee" for further clarity. In addition, Dr. Rahn called the committee's attention to a typographical error, noted on page 6 of the draft minutes which made reference to the "Medical Center of Georgia". He noted that this language should be corrected to read "Medical College of Georgia".

These corrections were duly noted. Following the acceptance of these two changes, a motion to accept the minutes was then unanimously accepted and approved by the Council.

CHAIRMAN'S REPORT

Dr. Rahn congratulated Glenda Battle on her reelection to the post as a County Commissioner in Decatur County and thanked her for her willingness to serve the citizens of the state. He then called on Dr. Baker to provide an update of the work of the Atlanta Regional Commission (ARC), which he presented at the Council's August meeting.

Dr. Baker provided a brief report noting that, in lieu of publishing a hard copy of the report entitled *Creating Healthy Neighborhoods: Using Community Voices & Existing Resources In The Five Core Counties Of Metropolitan Atlanta,* it has instead been posted on ARC's website. He said that it was felt that this format would allow ongoing updates to the document. Also, he reported his attendance at the Universal Healthcare Action Network Conference in Washington, D.C. Among the topics discussed at the conference were increases in healthcare expenditures, and challenges to the Social Security and Medicare and Medicaid systems.

Following his report, Dr. Rahn noted that in recent years the Chairman's report has provided information about the university system and about academic medicine. He indicated that he would provide an overview of academic health centers including national trends, research funding, and clinical care.

ACADEMIC HEALTH CENTERS

The external environment is challenging to academic health centers. Most of the advances in healthcare and medicine in the past 60-70 years can be attributed to work that has been done in academic health centers around the United States. They are unique in higher education in that they have one 'foot' in the academy of higher education and another in healthcare delivery. The success of the academic health center is tied to the ability to excel in clinical, research, and academic arenas. They cannot excel without being excellent in all three domains. Traditionally, the clinical enterprise has significantly cross-subsidized the academic and research enterprise. At present, there are major challenges to this structure. Among the things that impact academic health centers are state budgets. Nationally, state budgets are under duress and healthcare priorities have to be balanced with the need for higher education, particularly when they are both competing for limited dollars. The University System in Georgia has sustained nine rounds of budget reductions. Medical College of Georgia has sustained $19M in reductions over the last 3 years. The current appropriations are now lower than they were in FY2002 because there are insufficient resources available. Other states and other academic health centers around the nation are experiencing the same challenges.

RESEARCH FUNDING

Research is important because of advances in biomedical research and technology that lead to innovation in healthcare delivery. The University System is going through one of its best times with regard to National Institute of Health (NIH) Research funding. That budget doubled from 1998 to 2003 which has led to expansion of research funding and research infrastructure investment on academic health center campuses. The Medical College of Georgia is constructing a cancer research building, not associated with NIH funding. There is currently a public policy retrenchment and the NIH budget is rising 2% - 3% per year, keeping pace with the consumer price index but not continuing to grow. This poses a challenge to academic health centers to meet the costs associated with keeping up the infrastructure that is necessary to manage a research enterprise.

CLINICAL CARE

One of the challenges facing academic health centers is faculty shortages. This is making it difficult to recruit and retain faculty.

- Physician shortages—there is a nationwide shortage of anesthesiologists and radiologists.
- Dentistry--in the nation's 56 dental schools there are approximately 500 current vacancies.
- Nursing- there is a significant shortage of nurses. Credentialing requirements include one faculty member for every 10 nursing students to meet clinical education and BSN program requirements. Shortages of faculty are limiting the numbers of nurses that can be trained.
- Pharmacists-the state is currently experiencing a shortage of pharmacists.

INCREASING NUMBERS OF UNINSURED

There are approximately 45 million uninsured Americans. By most estimates, 80 million people were uninsured for a period of time within the last year. Academic health centers, by in large, provide about twice as much care to the uninsured as the average not-for-profit hospital system. Last year, costs associated with care of the uninsured at the Medical College of Georgia were approximately $100M. This is unsustainable over the long term given imminent reductions in Medicare and Medicaid reimbursements.

AGING PHYSICAL PLANTS

Fifty-percent (50%) of patient care facilities in the nation's academic health centers are more than 20 years old. Excluding Children's Medical Center at the Medical College of Georgia, which is less than ten years old, the remaining inpatient facilities are a minimum of 30 years old. Average cost of a replacement bed in a tertiary referral center is approximately $1M. This poses a huge financial burden in a tightening fiscal environment.

PATIENT SAFETY AND REDUCTION OF MEDICAL ERRORS

There are very large costs associated with information technology. Electronic medical records are important but the costs associated with this migration are staggering. There are increasing demands and major operational and fiscal pressures which threaten the ability of academic health centers to continue to function as they have in the past, including being the centers for science, education and preparation of the health profession's workforce of the future and the centers where the most innovation has come about and has been exported to the care delivery system. It is not that academic health centers should ever be the principal sites for care delivery but they do need to be the sites for much of the innovation that will be brought to patient care. There are major issues that have to be grappled with and the public has a major state in the well being of the nation's academic health centers. The power of the information technology and science are unquestionable.

The following comments were made following Dr. Rahn's presentation:

Ed Bonn : The magnitude of changes occurring in academic health centers is likely bigger and faster but is indicative of the entire industry. One of the things that the Council is charged with is conducting an ongoing evaluation of Georgia's existing healthcare resources. Is the Council sending a message that this is an industry in crisis? There have been hospital closures, decreases in reimbursement, and adjustments in Medicare. The basic ability to provide care to patients and the decreasing supply of practitioners, among other issues, are presenting significant challenges to the industry.

Toby Sidman -There should be some mechanism to communicate these system-wide challenges to organizations in local communities. Community organizations would be able to better educate local residents which could result in more educated patients. She volunteered to serve as the community liaison to achieve this goal.

- Inpatient Physical Rehabilitation Services TAC

Dr. Rahn noted that at the Council's August meeting the Department and the Council prioritized the work of several proposed technical advisory committees. The establishment of a TAC on Inpatient Physical Rehabilitation Services was listed as the number one priority. He announced that Harve Bauguess has agreed to chair this TAC and a list of potential individuals representing a wide spectrum of organizations have been identified to participate on the TAC. Dr. Rahn publicly thanked Mr. Bauguess for spearheading this effort and invited Council members to contact Stephanie Taylor if they are interested in participating on the TAC.

- FY 2004 Annual Report

Dr. Rahn said that included in member packets is a copy of the Council's draft FY 2004 Annual Report that was mailed to members prior to today's meeting. He asked for a motion to approve the Annual Report.

Charlene Hanson said that there is a lack of information in the Annual Report on rural health issues. Stephanie Taylor clarified that within the Department of Community Health an Office of Rural Health Services was established to address the state's rural health issues. She noted that the Division of Health Planning has collaborated with the Office of Rural Health Services and other stakeholders to develop the State's Rural Health Care Plan to allow rural hospitals to participate in the Medicare Rural Hospital Flexibility Program for critical access hospital designation. The Division of Health Planning has not been otherwise engaged in addressing rural health issues since the formation of the Office of Rural Health Services.

Ed Bonn stated that the Annual Report was well done. He asked about the functions of the Council which are delineated in the Annual Report under the overview section. Specifically, he asked whether the Council is involved in "studying the long-term comprehensive approaches to providing health insurance to the entire population". Dr. Rahn agreed that the Council is not currently involved in this activity. Mr. Bonn further asked if there would be opportunities for Council members to be involved in the Medicaid HMO discussions. Dr. Rahn indicated that he has met with Neal Childers, Richard Greene, and Commissioner Burgess and has offered the services of the Council to serve in an advisory capacity as plans are being developed. He indicated that the Council has not been invited to provide any input at this time.

Dr. Rahn indicated that the enabling legislation, which led to the creation of the Health Strategies Council as an advisory body to the Division of Health Planning, lists five primary domains of activity. The Council has statutory authority to engage in activities related to conducting ongoing evaluation of Georgia's healthcare resources for accessibility, including but not limited to financial, geographic, cultural, and administrative accessibility, quality, comprehensiveness, and cost and also to study long-term comprehensive approaches to providing health insurance to the entire population. He said that the Council has largely been focused on developing State Health Plans and Rules for administering the Certificate of Need program. He indicated that the "Overview" section of the Annual Report provides a statement of the statutory authority of the Council's activities. He indicated that if Council members

would like to engage in other activities, this could be further discussed later in the meeting, under the "Other Business" section of the agenda.

Mr. Bonn suggested that the Council should be engaged in discussions relating to physician shortage in Emergency Rooms. He indicated that CON laws have broadened and have allowed more physician competition. Additionally, he said that the impact of managed care and Medicaid cuts are also changing the healthcare landscape. He further indicated that he is aware of an initiative by the state that would have potential consequences to providers who do not perform well under a particular program. He said that it's his understanding that reimbursement could be affected under other contracts. He hopes that the state is planning to make a clear demarcation where participants would be prohibited from having such tie-in arrangements and agreements. He said that scrutiny would help to enhance participation by making sure that programs stay separate and distinct and that they are not blended such that excessive leverage could be used in one plan to achieve results of others.

Following this committee discussion Ed Bonn made a motion, seconded by Harve Bauguess to accept and approve the Annual Report. Council members unanimously approved the Annual Report as submitted.

DIVISION AND DEPARTMENT REPORT

Dr. Rahn called on Richard Greene to provide the Division and Department update.

DIVISION UPDATE

- ***Ambulatory Surgical Services Technical Advisory Committee***

Richard Greene indicated that the committee is still awaiting input from the Office of the Attorney General (AG). Mr. Childers indicated that he would followup with the AG and likely would provide a report at the next Council meeting.

- ***CPORT Study Update***

Mr. Greene indicated that the John's Hopkins Institutional Review Board has recently approved "CPORT II" study. He noted however that it will most likely require a statutory change before the Department is able to proceed. A pure rule change may not be adequate. He indicated that the Department has been waiting to see how the study would be designed. He said that there is some flexibility with the provider volume requirements for rural hospitals.

DEPARTMENT UPDATE

Mr. Greene called on Ms. Stroud to provide an update of the work of the Certificate of Need Program. Ms. Stroud indicated that there are presently 35 applications under review and 16 that are under appeal. She indicated that an Analyst, Jack Vincent recently retired from the CON section.

Following Ms. Stroud's report, Mr. Greene referred members to several inserts in member packets:

- Medicaid Managed Care Stakeholders Meeting (Tuesday, August 24, 2004), prepared by Carl Vinson Institute of Government, University of Georgia for the Department of Community Health
- Medicaid Reform Proposal Stakeholder Meeting (August 24, 2004)
- FY2006 Budget Proposal
- Proposed Reductions to Medicaid and PeachCare for Kids (three budget proposals)

Mr. Greene introduced Mr. Childers and called on him to provide a brief summary of the state budget. Mr. Childers indicated that materials were distributed to many stakeholders in late August. These materials can be downloaded directly from the Department's website. He further acknowledged that Dr. Rahn has conveyed the services of the Council in assisting the Department to work through many of these identified issues. He said that Commissioner Burgess has forwarded the Council's offer, which was favorably received, to the Governor's office. He indicated that the Governor's office has expressed an interest in obtaining greater input from the Council as program implementation moves forward.

Mr. Childers indicated that the Department held many stakeholder meetings with numerous segments of the healthcare industry, including hospitals, physicians, nurses, pharmacists, etc. and felt that this was a better way to gather feedback. The final proposal will incorporate significant input from stakeholders. He indicated that the Department does not have the luxury of spending as much time as everyone would like to review all facets of the report in detail. The Department is optimistic that there will be significant reductions in spending since it is not feasible for the state to continue with the current healthcare trend for state-paid health programs. He indicated that the State Health Benefit Plan is a mirror image of the Medicaid plan. He said that the Department would need an additional $300 million to support the State Health Benefit Plan and Medicaid if changes in the scope of these programs are not enacted. He said that the Department hopes that reductions would be achieved through decreased utilization rather than further provider rate cuts.

The following discussion ensued following Mr. Childers' presentation:

Ed Bonn- There is capacity to improve the utilization experience for our state's Medicaid population. We need incremental approaches.

Dr. Rahn - What percentage of the rate of rise is attributable to acute care?

Neal Childers- In response to Dr. Rahn's question, Mr. Childers indicated that he would investigate and provide this information to the Council at the next meeting.

Dan Rahn- Phase I is focused on the acute care services. What % of the total Medicaid budget is acute care?

Neal Childers: Approximately 40%. Sixty-percent (60%) of the people is responsible for 40% of the spending.

Dr. Rahn: The Department is hoping to get some budget predictability in the acute care component. Is that where the budget unpredictability resides? Does it reside in the acute care component? Per capita costs are not out of line/per enrollee. The southern region of the U.S. is among the lowest, but is rising at a relatively rapid rate as utilization goes up.

Ed Bonn - Georgia spends among the least of all states in the nation for capital spending towards Medicaid patients.

Neal Childers- Unfortunately, we have experienced increases across the board. Many factors including the recent economic downturn have resulted in an increase in the number of Medicaid recipients. Also, price, lead by pharmacy, continues to increase significantly. Utilization per capita is continuing to increase.

Dr. Conger- is the state doing as much as it could for certifying that the people receiving care are eligible? In the field of dentistry, there are many administrative and procedural errors. Many patients are manipulating the system and lots of "double-dipping" is occurring. Patients are using PeachCare at one time and Medicaid at another time and it's impossible for providers to keep up. This needs to be addressed at some time.

Neal Childers- The Department has signed a contract with a consulting firm to conduct an audit. They will conduct eligibility review for Medicaid. Also, the Department is expanding the capability of the Program Integrity Unit so that it is not only looking at fraud and abuse on the provider-side but also on the recipient-side. Given the relative number of providers versus recipients, it is difficult to address all of the recipient issues but the Department is attempting to collaborate with several local agencies including local police, sheriffs and the Office of the Attorney General to prosecute accordingly.

Charlene Hanson- it is difficult to separate workforce issues from other issues. Data from the work of the Healthcare Workforce Policy Advisory Committee indicates that Georgia will not have the number of providers that it will need. The right mix of professionals is critical. It is the full scope of health care professionals including nurses, lab techs, non-physician providers, pharmacists, etc that will be needed to ensure access to appropriate healthcare.

Dr. Rahn- Staffing patterns are different in different regions of the state. Thi**s** is a critical issue and it has to be part of the Department's plan in order to form care management organizations. Will they be able to provide the networks and will they have the quantity and types of providers who would participate?

Jim Peak-: Utilization is one critical component. In rural areas, unless there are incentives for the public not to over-utilize the emergency room this becomes the community's primary care center and their main entrance into the healthcare system.

Dr. Rahn summarized Mr. Childers's presentation noting that he presented the current status of the planning process for the restructuring of the acute care component of Medicaid. He indicated that the Department is seeking budget predictability and that the overarching strategy is to regionalize the state and contract with care management organizations, the specifics of which are under development at this time. The budgetary risk will be transferred from the state to the contractor. It will be the contractor's responsibility to meet the scope of services and to contract with providers in that region to meet the full spectrum of acute care services. There is a timetable for the development of this process and the expectation is that within the next fiscal year this model would be piloted in a region of the state. Total state rollout is uncertain at this time. State roll out of the program would depend on the success of the piloted program.

OTHER BUSINESS

Several members raised issues throughout the meeting which were deferred for discussion during this segment of the meeting. The first discussion revolved around some of the statutory responsibilities of the Council including the following: (specifically item #4)

1. Adopt the state health plan and submit it to the [Board of Community Health] for approval which shall include all of the components of the Council's functions and be regularly updated;
2. Review, comment on, and make recommendations to the Department on the proposed rules for the administration of this chapter, except emergency rules, prior to their adoption by the Department;
3. Conduct an ongoing evaluation of Georgia's existing health care resources for accessibility, including but not limited to financial, geographic, cultural, and administrative accessibility, quality, comprehensiveness, and cost;
4. Study long-term comprehensive approaches to providing health insurance to the entire population; and
5. Perform such other functions as may be specified for the Council by the Department or the Board of Community Health.

Mr. Childers indicated that one of the directives of the Commissioner is to become one agency where Department programs can become more integrated and coordinated. The Department has incorporated three prior agencies (Department of Medical Assistance, State Health Planning Agency and the State Health Benefit Plan). He indicated that each of these three agencies had advisory boards. The Council's role has been essentially to be involved in staffing

TACs and reviewing proposed rules and providing guidance with regard to the CON programs. The goal of Commissioner Burgess is to integrate the CON function and the Council more broadly into the Department. At present, the Division of Medical Assistance and the Division of Health Planning are collaborating on data collection to ensure one common data source and to reduce the administrative burden on providers. The Council has the ability, resources, and scope of knowledge to be a very important sounding board and to offer excellent input. The Department intends to more fully utilize the expertise of the Council on a more consistent basis.

Dr. Rahn- What real matrix is available to determine quality of life measure (other than infant mortality) in Georgia when restructuring of publicly funded healthcare is assessed? How will we know whether this is better/worse for the community?

Neal Childers-Outcomes measurement is a component of the restructuring process. It is not just a financial assessment. The Department is looking towards achieving better healthcare outcomes and some cost savings. The worse case scenario is that there was some cost savings but people were no better off. It is not acceptable to save money and to have worse health outcomes.

Ed Bonn - How do you align local, state and federal initiatives to achieve the same goals? The Joint Commission (and the National Institute of Health) has recognized core factors that look at (26) measures of quality in a hospital. The State of Georgia is ranked 48th of 50 states under this system. Priorities for the hospitals in the state changed based on some of the outcomes of this study. This planning process should be one that supports these initiatives. Sometimes committees' work is too narrowly focused. Many issues, including physician coverage in emergency rooms and physician competition with hospitals, among others are issues that should be discussed by the Council. Mr. Bonn said that there are greater access issues today, than was evident three years ago.

Kurt Stuenkel- The Council should monitor these issues and should be discussing the types of incentives that could be provided to encourage physicians to provide coverage to community hospitals. This is a statewide problem. When changes to financing of healthcare are evident there is a domino effect. Physicians, hospitals, and patients need to be working together. The Council should be a forum for these discussions.

Charlene Hanson -We do not have the data to study many of the problems. It is difficult to change something when no data exists.

Dr. Rahn- An additional problem is the regional trauma programs and Medicaid Reform. If hospitals are being retrospectively denied payment for increasing amounts of services in the ER it will become even more difficult for hospitals to provide trauma services. This is an access issue in many areas of the state.

Robert Rozier- Physician-hospital relationships is another area that needs to be discussed. Some of the service-specific regulations need to be looked at if the Department and the Council want to encourage better physician-hospital relationships and joint ventures. There are instances where projects can be approved just for hospitals or just for physicians but there isn't a precedent for joint relationships in the current rules.

Richard Greene- Asked members of the Council if there is data that the Department is not collecting? What other questions need to be asked on the Division's surveys? He encouraged input from Council members.

Kurt Stuenkel- Recommended that Council members generate a list of issues that are of importance. The Council should then prioritize this list and determine which areas are of critical importance and which the Council should work on in the coming year. Issues should not be overly broad. All information should be sent to Stephanie Taylor. This list should be categorized under the following headings (i.e. cultural, financial, geographic, accessibility, quality, cost). All information should be sent to Stephanie by December 15, 2004. The prioritized list should be shared with the Commissioner Burgess.

2005 QUARTERLY MEETING DATES

Dr. Rahn called on Stephanie Taylor to provide an overview of the Council's quarterly meetings. Ms. Taylor indicated that the upcoming meetings are as follows:

- Friday, February 25, 2005 (Atlanta, GA)
- Friday, May 29, 2005 (Augusta, GA)
- Friday, August 26, 2005
- Friday, November 18, 2005

She further indicated that she would contact the Chairs of the three Standing Committees to determine the dates for their annual meetings. The annual meetings are held during the month of January in order to provide a report to the Council at their February meeting.

There being no further business, the meeting adjourned at 1:15pm. Minutes taken on behalf of Chair by Stephanie Taylor.

Respectfully Submitted,

Daniel W. Rahn, MD
Chair